STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001148	A. BUILDING: _____ B. WING _____	R 07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	**17650 GENERATIONS DR SOUTH BEND, IN 46635**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on May 21, 2015. Survey date: 7-13-15 Facility number: 001148 Provider number: 001148 AIM number: N/A Census bed type: Residential: 58 Total: 58 Sample: 2 Wood Ridge Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.	{R 000}		